CALIFORNIA CORRECTIONAL HEALTH CARE SERVICES

REENTRY (REPS) DENTAL SERVICE REQUEST FORM

Email: CDCRCCHCSREPSDental@CDCR.ca.gov

☐ MCRP ☐ FCRP ☐ OTHER:		
Service is: ☐ **NON-URGENT** ☐ **URGENT** ABUSE OF URGENT PA STATUS WILL BE MONITORED. Urgent requests MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient, in the provider's best professional judgment. Services for urgent requests must be provided within 14 days of signing request. CCHCS reserves judgment of urgency and must meet definition above, therefore, please explain reason for urgency below.		Date:
Patient Name: (Last, First, Middle Initial)	Date of Birth:	CDCR #:

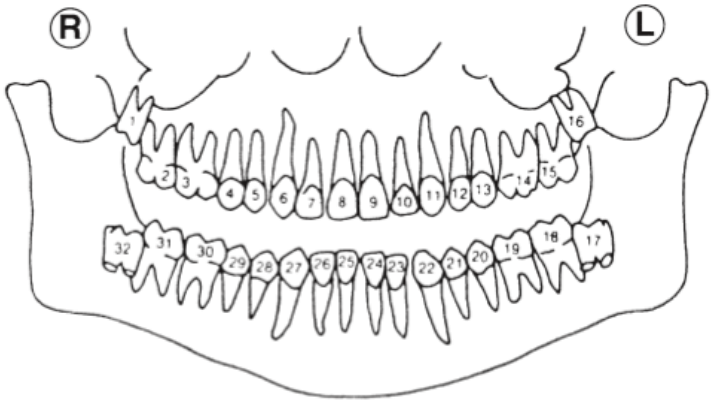
Referral/Service Type Requested

☐ Alveoplasty	☐ Biopsy/Lesion	☐ Cyst/Tumor
☐ Extraction	☐ Incision and Drainage	☐ Infection
☐ Tori Removal	☐ Oral/Facial Trauma	☐ Other:

Requesting Provider Information	Referring To Provider Information
Requesting Provider Name: (Last, First)	Referring To Provider Name: (Physician, mg.ipa, Facility, Agency)
Address: (No., Street, City, State, Zip)	Address: (No., Street, City, State, Zip)
Phone Number:	Phone Number:
Fax:	Fax:

Service Request Information

Please Circle Teeth or Area to be Treated



Comments or Concerns:

Requesting Dentist's Signature:	Date:

CDCR/CCHCS Dental Services Review

☐ APPROVED	COMMENTS:
☐ MODIFIED	
☐ DENIED	
CDCR ACDC Reviewer Signature:	Date:

CLAIMS PAYMENT IS CONTINGENT UPON PRIOR AUTHORIZATION OF SERVICE